DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 2 — 1 1

2. STATE: Virginia

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 2, 2002

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR Part 447

7. FEDERAL BUDGET IMPACT:
a. FFY 2002 $ 1,750,000
b. FFY 2003 $ 7,000,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19 A, pp 17.2 of 23;
Attachment 4.19 B, pp 4.2 and 7 of 15;
~~Attachment 4.19 D, pp 6,7 of 7~~
ATTACHMENT 4.19 A, PP 17.3 of 23
ATTACHMENT 4.19B, pp 4.3 of 15

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
4.19 A, p 17.2 - ADDS
4.19 B, pp 4.2 - Replaces
pp 7 Replaces
4.19 D, pp 6 and 7 - ADDS

10. SUBJECT OF AMENDMENT:

Upper Payment Limits - State Government-Owned

GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Secretary, Health and Human Resources

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Patrick W. Finnerty

14. TITLE:
Director

15. DATE SUBMITTED: 9/24/02

16. RETURN TO:

Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 9-27-02

18. DATE APPROVED: 12-24-02

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/02

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: CHARLENE BROWN

22. TITLE: Deputy Director

23. REMARKS: Pen and ink additions of attachments 4.19 A (page 17.3) and 4.19B (page 4.3)

FORM HCFA-179 (07-92)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT SERVICES

12 VAC 30-70-426. Supplemental payments to state government-owned hospitals for inpatient services.

A. In addition to payment for inpatient hospital services provided for elsewhere in this State Plan, DMAS makes supplemental payments to qualifying state government-owned hospitals for services provided to Medicaid patients on or after July 2, 2002. To qualify for a supplemental payment, the hospital must be part of a state academic health system or part of an academic health system that operates under a state authority.

B. The amount of the supplemental payment made to each qualifying state government-owned or operated hospital is determined by:

1. Calculating for each hospital the annual difference between the upper payment limit attributed to each qualifying hospital calculated according to D below and the amount otherwise actually paid for the services by the Medicaid program;
2. Dividing the difference determined in 1. for each qualifying hospital by the aggregate difference for all such qualifying hospitals; and
3. Multiplying the proportion determined in 2 above by the aggregate upper payment limit amount for all state owned or operated hospitals as determined in accordance with 42 CFR § 447.272 less all payments made to such hospitals other than under this section.
4. A payment made to a hospital under this provision when combined with other payments made under the state plan shall not exceed the limit in 42 CFR § 447.271 or the limit specified at 42 U.S.C. § 1396r-4(g). Any amount not included in a payment because of the operation of the preceding sentence shall be distributed to other qualifying hospitals in the same manner and subject to the same limitations as set forth above.

C. Payments for furnished services made under this section may be made in one or more installments at such times, within the fiscal year or thereafter, as is determined by DMAS.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT SERVICES

D. To determine the aggregate upper payment limit amount as referred to in B3 above, the following methodology will be used. For cost-reimbursed hospitals, the upper payment limit is costs. By definition, cost-reimbursed hospitals have no net impact on the upper payment limit and will be excluded from the calculation. For Medicaid DRG-reimbursed hospitals, a ratio will be calculated for each hospital by dividing its Medicare payments by Medicare charges. This Medicare payment-to-charge ratio will be multiplied by Medicaid charges for each DRG-reimbursed hospital. The upper payment limit will be the sum of the product of that multiplication for all DRG-reimbursed hospitals. The calculation will use data from the last settled cost report for all state government-owned hospitals at the beginning of the state fiscal year for which calculations are made. Charges will be trended forward using hospital-specific data if available. If not available, charges will be trended forward using the Virginia-specific DRI hospital inflation factors. Additional adjustments will be made for any program changes in Medicare or Medicaid payments. The most recently available data on Medicaid DSH payments will be used.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT SERVICES

8. Supplemental payments to state government-owned hospitals for outpatient services.

a. In addition to payments for services set forth elsewhere in this State Plan, DMAS provides supplemental payments to qualifying state government-owned or operated hospitals for outpatient services provided to Medicaid patients on or after July 2, 2002. To qualify for a supplemental payment, the hospital must be part of a state academic health system or part of an academic health system that operates under a state authority.

b. The amount of the supplemental payment made to each qualifying hospital is determined by:

(1) Calculating for each hospital the annual difference between the upper payment limit attributed to each qualifying hospital calculated according to d. below and the amount otherwise actually paid for the services by the Medicaid program;

(2) Dividing the difference determined in (1) for each qualifying hospital by the aggregate difference for all such qualifying hospitals; and

(3) Multiplying the proportion determined in (2) by the aggregate upper payment limit amount for all state owned or operated hospitals as determined in accordance with 42 CFR § 447.321 less all payments made to such hospitals other than under this section.

(4) A payment made to a hospital under this provision when combined with other payments made under the state plan shall not exceed the limit specified at 42 U.S.C. § 1396r-4(g). Any amount not included in a payment because of the operation of the preceding sentence shall be distributed to other qualifying hospitals in the same manner and subject to the same limitations as set forth above.

c. Payments for furnished services under this section may be made in one or more installments at such times, within the fiscal year or thereafter, as is determined by DMAS.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT SERVICES

d. To determine the aggregate upper payment limit amount referred to in (b 3) above, the following methodology will be used. A ratio will be calculated for each hospital by dividing its Medicare payments by Medicare charges. This Medicare payment-to-charge ratio will be multiplied by the Medicaid charges for each hospital. The upper payment limit will be the sum of the product of that multiplication for all hospitals. The calculation will use data from the most recently settled cost report for all state government-owned hospitals at the beginning of the state fiscal year for which calculations are made. Charges will be trended forward using hospital-specific data if available. If not available, charges will be trended forward using the Virginia-specific DRI hospital inflation factors. Additional adjustments will be made for any program changes in Medicare or Medicaid payments. The most recently available data on Medicaid DSH payments will be used.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT SERVICES

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12 VAC 30-80-30 A. (continued)

16. Supplemental payments to state government-owned or operated clinics.

a. In addition to payment for clinic services specified elsewhere in this State Plan, DMAS provides supplemental payments for outpatient clinic services provided to Medicaid patients on or after July 2, 2002. Clinic means a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. Outpatient services include those furnished by or under the direction of a physician, dentist, or other medical professional acting within the scope of his license to an eligible individual. Supplemental payments will be made to Children's Specialty Services, a state government-owned and operated clinic.

b. The amount of the supplemental payment made to Children's Specialty Services is determined by calculating for all state government-owned or operated clinics the annual difference between the aggregate upper payment limit specified in 42 CFR § 447.321 and determined according to the method described in (d) below and the amount otherwise actually paid for the services by the Medicaid program;

c. Payments for furnished services made under this section may be made in one or more installments at such times, within the fiscal year or thereafter, as is determined by DMAS.

d. To determine the aggregate upper payment limit, Medicaid payments to state government-owned or operated clinics will be divided by the "additional factor" whose calculation is described in Attachment 4.19-B, Supplement 4 (12 VAC 30-80-190 B) in regards to the state agency fee schedule for RBRVS. Medicaid payments will be estimated using payments for dates of service from the prior fiscal year adjusted for expected claim payments. Additional adjustments will be made for any program changes in Medicare or Medicaid payments.